i. Provide I/T/U providers, whether participating in the network or not, payment for covered services provided to Indian members who are eligible to receive services from these providers either:

a) At a rate negotiated between the MCO and the I/T/U provider, or

b) If there is not a negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

ii. Make prompt payment to all I/T/U providers in its network in compliance with Federal regulations regarding payments to practitioners in individual or group practices, per 42 CFR 447.45 and 447.46.

b. Additional required Indian health protections are included in Section IV.F Member Services and Education.

5. Psychiatric Residential Treatment Facilities

The MCO's rate of reimbursement for psychiatric residential treatment facilities must be no less than the published Medicaid FFS rate on the date of service.

6. Value-Based Contracting

a. It is the policy of MLTC that HERITAGE HEALTH should promote added value for members and providers. Value is captured through programs that improve outcomes and lower costs. Contracted providers shall be engaged in the pursuit of improved value. A key mechanism to achieve this is through value-based contracting arrangements. For purposes of this contract, value-based contracts are defined as payment and contractual arrangements with providers that include two components:

i. Provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics, and

ii. Payment methodologies that align their financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

b. The MCO must enter into value-based purchasing agreements with 30% of its provider network by the third year of the contract, and 50% of its provider network by the fifth year of the contract.. By the end of the first year of the contract, the MCO must submit to MLTC for its review and approval its plan for implementing value-based purchasing agreements. In its response to this RFP, the MCO shall describe its philosophy regarding value-based purchasing agreements and provide evidence of its effective use in the State or other markets.

c. The MCO must notify MLTC of any risk-sharing agreements it has negotiated with a provider within 15 calendar days of any contract signing with the provider containing this provision. Any provider contract that includes capitation payments must require the submission of encounter data within 90 calendar days of the date of service. As applicable, the provider contracts must comply with the requirements set forth in Section IV.I Provider Network Requirements of this RFP and in compliance with 42 CFR 434.6. The MCO must maintain all provider contracts in compliance with the provisions specified in 42 CFR 438.12 and 42 CFR 438.214, as well as this RFP. MLTC reserves the right to direct the MCO to terminate or modify any provider contract if MLTC determines that the modification or termination is in the best interest of the State.

7. Physician Incentive Plans

a. The MCO's physician incentive plans must meet the requirements of 42 CFR 422.208 and 422.210.

b. A physician incentive plan cannot make a payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member.

c. The MCO must submit any contract templates that include an incentive plan to MLTC for review and approval a minimum of 60 calendar days prior to their intended use. Any provider incentive plan must receive prior MLTC approval. The MCO must disclose the following information in advance to MLTC:

i. Services furnished by physician/groups that are covered by any incentive plan.

ii. Type of incentive arrangement (e.g., withhold, bonus, or capitation).

iii. Percent of withhold or bonus (if applicable).

iv. Panel size, and if patients are pooled, the method used.

v. If the physician/group is at substantial financial risk, documentation that the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss.

d. If the physician/group is put at substantial financial risk for services not provided by the physician/group, the MCO must ensure adequate stop-loss protection for individual physicians and conduct annual member and provider satisfaction surveys.

e. The MCO must provide the information specified in 42 CFR 422.210(b) regarding its physician incentive plan to any Medicaid member on request.

f. If required to conduct member and provider satisfaction surveys (as described in Sections IV.F Member Services and Education and IV.J Provider Services), survey results must be disclosed to MLTC and, on request, to members.

8. Payments to Out-of-Network Providers

a. If the MCO is unable to provide necessary services to a member within its network, the MCO must adequately and timely arrange for the provision of these services out-of-network. In these circumstances, the MCO must ensure that any prior authorization and payment issues are resolved expeditiously.

b. The MCO must ensure that, if applicable, the cost to the member is no greater than it would have been if the services were furnished within the network.

c. For services that do not meet the definition of emergency services, the MCO is not required, unless otherwise provided for in this contract, to reimburse out-of-network providers at more than 90% of the Medicaid rate in effect on the date of service to providers with whom/which it has made a minimum of three (3) documented attempts to contract.

d. The MCO must pay for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of these services. The MCO must reimburse emergency service providers 100% of the Medicaid rate in effect on the date of service. In compliance with Section 6085 of the Deficit Reduction Act of 2005, this requirement also applies to out-of-network providers.

e. During the initial 90 calendar days of the contract, the MCO must pay out-of-network providers at 100% of the Medicaid FFS rate, to support member continuity of care.

f. The MCO may require prior authorization for out-of network services, unless those services are required to treat an emergency medical condition.

g. MCO members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions. The out-of-network provider must bill the MCO and be reimbursed at no less than the Medicaid rate in effect on the date of service.

h. MCO members shall be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No